

ISSA Proceedings 2010 - Institutional Constraints On The (Un)Sound Use Of The Argument From Expert Opinion In The Medical Context



1. Introduction

The present paper stems from a larger research project [i] aimed at describing the most relevant features of the institutional context that constrain interactions between doctors and patients during medical consultations within the framework of the Italian National Health Care Service.

The project takes into consideration the persuasive moves within the consultations in order to identify the most effective arguments and possible unsound persuasive strategies. Particular attention is placed on the institutional features of the context within which the analyzed consultations are set. This choice is justified by the crucial role that the context plays in any kind of verbal interaction; for the analysis of medical consultations this is doubly important as the institutional context they occur in is highly regulated and conventionalized, and also the roles of doctor and patient have some context- and culture-dependent features, which can have a certain import on the development of the consultation (see Bigi 2010). Building also on previous research (Bigi submitted), the present paper aims to identify the contextual features that may lead to unsound uses of the argument from expert opinion.

The paper is structured as follows: paragraph 2 presents a brief review of the relevant literature on the argument scheme from authority or from expert opinion. This will show the general agreement on the validity of this argument scheme along with its main limitations. In paragraph 3, the contextual constraints on the medical consultation are described. The Italian health care system is described from the point of view of its overall structure in order to highlight the main institutional features that can constrain the development of the consultation, the structure of which is then described. In paragraph 4, two main conditions that

favor unsound uses of the argument from expert opinion are described. The final paragraph is devoted to some concluding remarks.

2. *The inferential validity of the argument from expert opinion*

Appealing to the speaker's character, skills, knowledge, or social authority (*ethos*) has been acknowledged since Aristotle's time as a valid means of persuasion, but after Locke's inclusion of the argument *ad verecundiam* in the list of fallacies, appeals to authority have sometimes been regarded with suspicion. There came to be disagreement about whether appeals of such kind had rational force or were unsound means of persuasion (Goodwin 1998: 267). It is necessary to distinguish between different kinds of authority and scholars agree at least on the distinction between the authority of the witness and the one of the expert. In less institutionalized contexts it is also possible to find the authority of a 'wise person' who offers advice and the one of a friend who offers suggestions which are taken to be trustworthy because of the benevolence the friend is supposed to have towards the one who is asking for advice. Recent studies on the argument from expert opinion grant it legitimacy as a sound strategy given certain contextual conditions (van Eemeren & Houtlosser 2003; Jovičić 2004; Walton 2006; Godden & Walton 2006; Rigotti & Palmieri 2008). As for the structure of this argument, two main approaches will be considered, the one presented in Walton (2006) and Godden & Walton (2006), and the one outlined in Rigotti & Palmieri (2008).

In Walton (2006: 750), the argument from expert opinion is described in the following way:

Source Premise: Source *E* is an expert in the subject domain *S* containing proposition *A*.

Assertion Premise: *E* asserts that proposition *A* (in domain *S*) is true (false).

Warrant Premise: If source *E* is an expert in subject domain *S* containing proposition *A*, and *E* asserts that proposition *A* (in domain *S*) is true (false), then *A* may plausibly be taken to be true (false).

Conclusion: *A* may plausibly be taken to be true (false).

Here the warrant premise is defined as "a defeasible conditional. It has the form of a Toulmin warrant, meaning that it does not hold universally, but only subject to exceptions or countervailing instances that may arise". (Walton 2006: 750) An analogous description is given in Godden & Walton (2006: 277):

Major Premise: Source *E* is an expert in subject domain *S* containing proposition *A*.

Minor Premise: *E* asserts that proposition *A* is true (false).

Conclusion: *A* is true (false).

Both descriptions are accompanied by a list of six critical questions, which need to be answered satisfactorily in order for the appeal to expert opinion to be admissible (Walton 2006: 750):

1. *Expertise Question*: How credible is *E* as an expert source?
2. *Field Question*: Is *E* an expert in the field that *A* is in?
3. *Opinion Question*: What did *E* assert that implies *A*?
4. *Trustworthiness Question*: Is *E* personally reliable as a source?
5. *Consistency Question*: Is *A* consistent with what other experts assert?
6. *Backup Evidence Question*: Is *E*'s assertion based on evidence?

Rigotti & Palmieri (2008) base their description of the argument from authority on the model for the description of *loci* presented in Rigotti (2006) and Rigotti & Greco Morasso (2010). By referring to the moral or professional quality of the speaker, the *locus* from authority is considered as a subtype of the *locus* from efficient cause. The *speaker* corresponds to the efficient cause, the *statement* corresponds to the product, and the logical maxim from which the reasoning develops is of the kind: 'if the efficient cause of a product is valid, the product is valid'; the validity of a statement as a particular kind of product is its truth. The *locus* from authority also shows some additional components belonging to the communicative situation in which the standpoint is being discussed. (Rigotti 2006: 528-529). These additional components are basically the *source of the authority* and the *assessment of the authority*. In the argument from expert opinion, the source of the authority depends on the different types of statements expressing the standpoint, but also on the process of constitution of the authority. As for the assessment of the authority, it is obtained by posing certain critical questions, by a process of analogy in which past judgments on the expert are considered, and by questioning the *endoxon* founding the expertise of the expert. Additional *loci* could be involved depending on the critical questions (for example, the *locus* from the final cause can be involved in the case of a conflict of interests) (Rigotti & Palmieri 2008).

Though different in many respects, the two descriptions share some basic elements. The first is the fact that the soundness of this argument rests largely on the source of the authority, which needs to be clear and acknowledged as reliable by all participants in the discussion. Also other scholars agree on this point. Van

Eemeren & Houtlosser (2003) posit this as one of the conditions that determine the (un)soundness of the argument from expert opinion: the expertise of the expert must be agreed upon. To this, they also add the necessity for an agreement on the need itself for an appeal to authority. The authors describe this argument as a 'symptomatic argument scheme, in which the argument provides a sign that the standpoint is acceptable'. The sign consists precisely in the reference to an external source of expertise (van Eemeren & Houtlosser 2003: 296). If there is no agreement on the authority or on the need for an appeal to authority, then the argument derails and turns into an *ad verecundiam* fallacy. A similar position is found in Jovičić (2004), where particular stress is placed on the fact that the invoked authority must have been ratified by the arguers. Trying to find a method to distinguish between different kinds of authority, Goodwin (1998) proposes the following principle: different kinds of authority should be distinguished relying on the reaction that a failure to follow them ordinarily evokes. Goodwin identifies three main types of authority: expertise, command and dignity. Failure to follow them results, correspondingly, in imprudence, punishment and impudence.

Regarding the source of the authority, it can also be observed that there are different ways in which the authority of the expert is acknowledged: in the example proposed by Jovičić (2004) the authority of the experts is agreed upon by a group of non experts, who go through a process of assessment and in the end decide not to rely on those who in the beginning they had considered as trustworthy. In this case the authority of the experts is proposed as legitimate by the experts themselves, initially accepted by the group of non experts, and eventually rejected because unable to meet the critical requirements of the non experts. There is also the case of the experts whose expertise is initially ratified by their peers, and only afterwards needs to be acknowledged by the non-experts. In this case the process of assessment is somewhat different from the previous one, as part of it is left to the expert's peers, whose criteria for the evaluation depend on the particular field of expertise. The second basic element playing an important role for the argument from authority is the assessment of the authority. Both Walton and Rigotti refer to critical questions that should be posed in order to evaluate the soundness of the argument. It is particularly Walton who discusses at length the conditions for the validity of the argument from expert opinion. His focus is mainly on the assessment of the admissibility of expert opinions in legal trials; therefore the context he refers to has very specific constraints. Nevertheless certain observations have a general validity. Regarding the dialogue

in which an expert is questioned on his/her area of expertise, Walton (1997; 2006) observes that, in spite of its being mainly an information-seeking kind of dialogue, it may and should present intervals or shifts that are argumentative in nature. This happens when the questioner tries to probe into what the expert is saying, both to understand it and to test it out. Therefore, a fallacious use of the argument from authority does not only consist in failure to address critical questions that need to be asked, but also in limiting or shutting down the possibility for the questioner to shift to this argumentative interval in which he tries to assess the credibility of the expert and to understand what he is being told. Walton identifies the three main forms of this interval: clarification of meaning; making logical sense of what the expert said; searching justification for a claim.

As for the fallacious uses of the argument from expert opinion, Walton observes that very often these uses occur when the boundary between cognitive (deriving from knowledge) and administrative (deriving from social role) authority is not clear (1997: 76). He also proposes to consider the *ad verecundiam* fallacy only as the case of the dogmatic use of the argument from expert opinion, i.e. a use of such argument that blocks the non expert from posing any of the six critical questions the answers to which allow to assess the valid use of the argument from expert opinion.

Walton puts forward a typology of fallacious uses of this argument scheme. When the *Expertise Question* ("how credible is E as an expert source?") is blocked, there is the *fallacy of nonauthority*. Subfallacies under this fallacy are the *fallacy of appeal to celebrity* and the *fallacy of unidentified authority*. Under the *Field Question* ("is E an expert in the field that A is in?") the *fallacy of misplaced authority* may occur when the field is definitely wrong. Under the *Opinion Question* ("what did E assert that implies A?"), the *fallacy of misrepresented authority* occurs if what E said is being misrepresented in a deceptive way. In this case, it is possible to have also the subfallacies of *misquoting an authority* and *wrenching what an authority said out of context*. Regarding the *Trustworthiness Question* ("is E personally reliable as a source?"), the subfallacies of *concealing the dishonesty of an authority*, *concealing the bias of an authority* and *concealing the lack of conscientiousness of an authority* may be used to block this critical question. The *Consistency Question* ("is A consistent with what other experts assert?") may be blocked by *DeMorgan's subfallacy* of putting together two

propositions belonging to two different experts and deriving by them a third proposition, putting it forward as a conclusion supported by the experts. In this domain the *subfallacy of concealing deviance of an expert opinion* may occur, where the opinion is presented as though it were generally accepted in the field of expertise when in fact this is not true. (Walton 1997: 254-255)

Scholars therefore seem to agree on the fact that the argument from authority in general and from expert opinion in particular is valid from an inferential point of view; the risk for it to be fallacious does not derive from its inferential structure but from *how* it is used in a specific context. The medical context, in particular, displays certain typical constraints and touches on specific issues that can play crucial roles in the development of the interaction between doctors and patients during the consultation. These will be dealt with in the following paragraph. The Italian National Health Care Service has been chosen due to the fact that the project relies on video-recordings of real life consultations recorded in an Italian hospital.

3. The contextual constraints on the medical consultation.

Italy's health care system as we know it today was officially born in 1978, in an effort to make health care widely accessible and rationally organized through large-scale planning (Centro di ricerca sulle amministrazioni pubbliche "V. Bachelet", 2008: 4-12). The system is organized in three basic levels: the national, the regional and the local one. At the national level, the National Health Care Service (*Servizio Sanitario Nazionale, SSN*) provides the institutional structure within which to organize more specific actions. It has a function of planning and coordination. Every three years it provides a National Health Care Plan (*Piano Sanitario Nazionale*) in which the distribution of resources is decided, along with the national goals to be met. At the regional level, we find the Regional Health Care Service (*Servizio Sanitario Regionale, SSR*). Each Region receives resources from the government according to what has been budgeted in the National Health Care Plan, and is required to draw up an analogous Regional Health Care Plan, which will allow to contribute to the attainment of the national goals respecting the specific characteristics of each single region. Regions are completely autonomous in the allocation of resources and in devising the strategies needed to meet the goals set at the national level. At the local level, units of health care provision are called Local Health Care Units (*Aziende Sanitarie Locali*). The citizens relate to this complex structure potentially at any level, actually at the

highest and at the lowest point: at the highest level indirectly, because through elections citizens choose the politicians who will work in the Ministry; at the lowest directly, when they need health care and they engage in interactions with health care providers. The law grants citizens/patients ample margin for action and protects them in various ways, but surely it cannot eliminate the complexity of a system that at times 'looms' over the patient, humbling him more often than not. The practical difficulty of accessing the health care system is the first contextual factor that plays a significant role in the perception of authority within the interaction. Another problematic side of this bureaucratic system is the fact that it is closely interwoven with offices that are part of the government. In the Italian culture this creates the premises for a persistent Trustworthiness Question, which is very difficult to answer. Moreover a relevant factor that comes into play in the decisions made by doctors is the financial one. In the Italian health care system, clear instructions are given as to which drugs are covered by the national health care system and which aren't, which exams should be kept to a minimum and which can be prescribed more frequently, etc. The "budgetary preoccupation" clearly plays a role when it comes to making therapeutic decisions, but patients may not be aware of it.

However, once the patient has finally managed an appointment with the physician, other contextual constraints come into play, which are related to the topic at issue in the consultation (i.e. the patient's health) and to the structure of the consultation itself. It is in particular in the past fifty years that a considerable amount of literature has been produced on the topic of the medical consultation, on its structure and on the best methods to assess its quality (Wasserman & Inui 1983; Ong et al. 1995; Boon & Steward 1998; Mead & Bower 2000; Rimal 2001; Beck et al. 2002; Borrell-Carrio et al. 2004; Hornberger & Robertus 2005; Wirtz et al. 2006). It has been observed that the consultation displays a rather fixed structure, in which both patients and physicians enter with expectations regarding the asymmetry of their roles, and where all their discursive moves tend to enact and confirm the asymmetry between them. (Pomerantz & Rintel 2004). The consultation is an activity type which is generally structured in a certain number of phases, determined by the communicative goal, which are: the opening, the history, the physical examination, patient education and counseling, and the closing (Roter & Hall 2006: 113-116). The structure itself of this activity type presupposes a leading figure in charge of naming the problem (diagnosis) and finding a solution (therapeutic suggestion), and a subordinate one (the

patient) who embodies the problem and is the 'object' of observation. This asymmetry between the two roles, unavoidable as it may be, can carry the risk of blurring the boundary between cognitive and administrative authority and giving way to unsound uses of the argument from expert opinion. A nice example of this is found in the following extract from a real life consultation. Here the patient has been given a "light" treatment and goes to see the doctor for a routine check-up. Seeing that the physician doesn't seem to be willing to intensify her therapy, the patient expresses her perplexity **[ii]**:

Pa.: But, actually, when my blood pressure goes up so high, I am at risk, because they told me it's risky...

Ph.: Well, no, I wouldn't say so, I mean with these numbers, with your numbers, they are not so terrible.

Pa.: Because, also the other doctor...

Ph.: No, please, don't start panicking because the situation could really get worse. For sure these numbers are high, if they don't drop or if they should rise, we would surely need to treat them, this is for sure, but now, well, I would really say...

This is a typical example in which the patient is not allowed to shift to the argumentative subdialogue that would have allowed her to make sense of the conflicting opinions she had been given, thus yielding an unsound use of the argument from expert opinion.

The feature that most typically characterizes the interaction between a doctor and a patient is the fact that the interlocutors share a very limited common ground. This, together with the features of the institutional context we have described so far (structural complexity; asymmetry in the familiarity with the institution; asymmetry of social roles), may make it very difficult for doctors to involve patients in the process of decision-making. It is clear that in order to make a decision a subject must have data on which to base it. But if the context of the interaction makes it too difficult to provide all the relevant data, as is often the case in an asymmetric interaction (Ford 2002), what arguments can be used to motivate a certain decision? Given the topic in this specific field of interaction, the most relevant arguments would appear to be the effects, the causes, the risks, or the expertise of the person who proposes the solution. Indeed it is very difficult for patients to base their own decision making on the same premises on which the doctor bases it. Thus we are led to the problem of unshared premises: doctors are

likely to base their decisions on premises that belong to the specialized domain they are experts of. These are difficult to explain to a non-expert in the limited time of a consultation. Therefore the common ground for the shared decision-making has to be found elsewhere. The expertise of the expert can be considered part of the shared common ground, on the condition that the patient trusts the doctor. However a systematic study should be conducted on which are the most effective arguments and emotions that contribute to the goal of persuading a non-expert in a context such as the one described so far.

The next paragraph will be devoted to the discussion of two conditions that can favor the occurrence of unsound uses of the argument from expert opinion: the 'structural' difficulty of assessing the expertise of the expert, and the problem of unshared goals.

4. Possible unsound uses of the argument from expert opinion in the medical context.

The complexity of the health care system, which has been described in the previous paragraph, is at the heart of a fundamental problem, i.e. the difficulty of assessing the expertise of the expert. In the medical context, above and before the direct interaction between the expert and the non-expert, the expertise of the former has been acknowledged and ratified by the scientific community the expert belongs to. Assuming that the scientific community has applied the relevant criteria and has acknowledged someone as an expert in a certain field, an institution then employs the expert where he/she will serve as a professional. This second step is also very important, and it presents one advantage and one disadvantage for the patient who is in need of the opinion of a doctor. The advantage consists in the fact that the system operates a selection among the potential experts applying criteria that are relevant to the field of expertise and to the needs of the system itself. In other words, when a scientist is acknowledged as trustworthy by its peers, it is expected that they will have used scientific criteria to recognize him/her as trustworthy, and not, for example, criteria related to the person's character, wealth, etc. Also, when selecting the experts to employ, a hospital or a research center is expected to take into consideration the needs of the population living in the area and the resources available: a hospital in a highly industrialized area of northern Italy is less likely to need an expert in tropical diseases and will probably avoid spending all its money on someone whose performances cannot be sustained by a limited budget. This is an advantage for

the non-expert, because it is more likely that the expert can be acknowledged as such if the assessment of his/her expertise has been performed by applying relevant criteria, which the non-expert generally does not know. The disadvantage in this situation is that it becomes extremely difficult for the non-expert to personally verify the reliability of the expert. Indeed the non-expert comes into play at the end of a long process of selection, the workings of which he ignores. For this reason, before entering an interaction with an expert, the patient often looks for information from alternative sources, such as friends, family, the Internet, the press (Forum per la Ricerca Biomedica [Forum for Biomedical Research] 2007). Such a patient is the most likely to ask frequent questions to the physician, but also the one more apt to be suspicious when the expert's suggestions are not in agreement with the information previously retrieved. A situation of conflicting authorities may arise, a case in which doctors' argumentative abilities are very important if they do not want to lose their patients' trust. The following is another extract from a real life consultation, which shows an interesting solution to a case of conflicting authorities. The consultation is a follow-up from a previous one. The physician is going over the patient's treatment and at a certain point asks:

Ph.: I suppose you are regularly taking your low dose aspirin, right?

Pa.: Aspirin... I totally forgot.

Ph.: You remember we decided that...

Pa.: Yes, yes

Ph.: [...]

Pa.: No, I really just totally forgot, I have to go buy it.

Ph.: This is something that can help us, low dose aspirin [...]

Pa.: Yes, right, by the way, I wanted to ask you something. I read on the leaflet inside the Adalat Crono box, actually also in the Lacirex **[iii]** one, that it says something about not taking acetylsalicylic acid...

Ph.: No, no, no, on the contrary. There are studies based on controlled trials showing that low dose aspirin associated with anti-hypertension therapy has a protective effect.

Pa.: I took it for a couple of days, and then...

Ph.: Do take it, trust me. Unless there are serious contraindications like ulcer, hemorrhagic gastritis..., then it's a different thing. But you don't have anything like that so, aspirin is useful in those dosages.

The physician refers to a higher authority, the one of evidence-based medicine,

which heavily relies on the system of controlled trials. The use of the argument from expert opinion here is not fallacious, as the system of controlled trials actually is reliable and acknowledged as such by the scientific community; this use could be persuasively weak though because the patient may not be aware of the authority of controlled trials. Indeed this case is exemplary of a frequent 'solution' doctors find to the problem of conflicting authority, i.e. shifting the burden of proof to the researchers who have produced the results the doctors themselves rely on to formulate their suggestions. This of course contributes to the making the assessment of the expertise of the expert even more difficult.

Another feature characterizing the interaction between doctors and patients, which could indirectly favor a fallacious use of the argument from expert opinion, is the existence of unshared goals. Sometimes patients see their doctor because they think they can recover completely when in fact this is not possible (e.g. elderly patients; chronic patients). It often happens that the goals of the actions suggested by the physician remain implicit, because the doctor simply does not say what he has in mind when he suggests a certain course of action. This may create possible conflicts, which could also remain implicit and escalate to the point of destruction of the whole relationship between doctor and patient. In this case the process of presuppositional accommodation may play a relevant role **[iv]**. The fact that doctors frequently introduce presupposed content in the common ground together with the asserted content, taking for granted that their patients are aware of this and agree both with the process and with the truth of the presupposed content can create a problematic situation. The fact that the patient accommodates does not imply that he accepts or believes everything the doctor is saying. In this context therefore, the process of presuppositional accommodation becomes something to consider very carefully: it cannot be avoided, but it is more likely to bear positive outcomes if the relationship between doctor and patient is based on trust and understanding. Indeed, forcing the acceptance of a certain course of action grounding the argumentation on presupposed (specialized) content actually amounts to one of the cases of fallacious use of the argument from expert opinion, as it is a process that may prevent the non-expert from discussing the decision in order to understand it.

Moreover, the issue of unshared goals in this context could be reframed also as an agency problem. The relationship between doctor and patient can be construed as a kind of agency relationship, in which a principal (the patient) delegates a task to

an agent (the doctor) (Goodwin 2010). The Italian National Health Service is structured in this way, having the patient at its center (Bigi 2008), as is also reflected in its name, 'service'. When fallacious cases of the argument from expert opinion occur, they are not only argumentative fallacies, but also instances of shirking on the part of the doctor. Is it possible to reduce this risk? Are there cultural perceptions of authority that could encourage doctors to abuse of their position? Perhaps further research could inquire into the cultural perception of the concepts of 'authority', 'public institutions', 'public service'.

5. Concluding remarks.

The argument from expert opinion has been shown to be inferentially valid, but heavily dependent on certain contextual factors for its soundness and persuasive strength. The main contextual factors it depends on are the *source* of the authority invoked and the possibility to *assess* the expertise of the authority. We set out at the beginning of this article with the aim of observing the argument from expert opinion within the context of the medical consultation in order identify the contextual constraints that may favor an unsound use of this argument. The article has examined the institutional structure of the Italian health system, and the development and structure of the consultation, along with some key issues related to it.

It is possible now to draw a few conclusions. First of all, the institutional structure of the Italian health care system, in spite of its being designed around the patient and with the aim of achieving patients' well being and public health, appears to be rather complex and difficult to relate to. This favors a feeling of uneasiness and inferiority in the patient, and conversely a feeling of superiority in the professional who works within the structure and knows its inner workings very well. This creates an asymmetry not only in the specialized knowledge of the two interagents, but also in what we could call the 'systemic' knowledge of the two, which could easily favor fallacious uses of the argument from expert opinion. Considering the way the health care system is constructed, fallacious uses of the argument from authority can be said to amount to shirking on the part of the doctor (agent), who is supposed to pass on relevant information to the patient (principal) and to work for the preservation of public health. Therefore, when the argument from expert opinion is based on the doctor's administrative authority rather than on the cognitive one, it can be considered invalid. The system being constructed as it is, doctors should be particularly careful in the way they use this

argument scheme. With regard to this point, a deeper inquiry into the perception of authority and the function of institutions in the Italian culture is likely to yield very interesting insights.

NOTES

[i] The project is funded by a Research Fellowship awarded by the Faculty of Foreign Languages at the Catholic University of Milan (Italy).

[ii] This extract and the one that follows are taken from longer interactions, videorecorded between 2004 and 2005 at the Hypertension Division of the San Paolo Hospital in Milan (Italy). Both consultations are taken from the Archive of Videorecordings of Medical Consultations at the Institute of Medical Psychology of the San Paolo Hospital in Milan.

[iii] Adalat Crono and Lacirex are drugs the patient has been taking for his anti-hypertension therapy.

[iv] On the role of presuppositional accommodation in dialogue and its manipulative uses, see Greco (2003).

REFERENCES

Bigi, S. (submitted). The persuasive role of ethos in doctor-patient interactions. *Communication and Medicine*.

Bigi, S. (2010). Analyzing doctor-patient communication: methodological issues. *Bulletin suisse de linguistique appliquée*, 2, 133-145.

Bigi, S. (2008). The relevance of *agency* for describing and evaluating doctor-patient interactions. Paper presented at the 14th Qualitative Health Research Conference, 3-6 October 2008, Banff Centre, Banff (Canada).

Beck, R.S., Daughtridge, R. & Sloane, P.D. (2002). Physician-patient communication in the primary care office: a systematic review. *Journal of the American Board of Family Medicine*, 15(1), 25-38.

Boon, H. & Steward, M. (1998). Patient-physician communication assessment instruments: 1986 to 1996 in review. *Patient Education and Counseling*, 35, 161-176.

Borrell-Carrio, F., Suchman, A.L. & Epstein, M.R. (2004). The Biopsychosocial Model 25 Years Later: Principles, Practice and Scientific Inquiry. *Annals of Family Medicine*, 2(6), 576-582.

Centro di ricerca sulle amministrazioni pubbliche "V. Bachelet" (2008). *Libro bianco sui principi fondamentali del Servizio Sanitario Nazionale* [Whitepaper on the Fundamental Principles of the National Health Care Service]. Libera

- Università di Studi Sociali - Luiss "Guido Carli". Retrieved 28 June, 2010, from: http://www.salute.gov.it/imgs/C_17_publicazioni_808_allegato.pdf.
- Eemeren, F.van, & Houtlosser, P. (2003). Fallacies as derailments of strategic maneuvering: the *argumentum ad verecundiam*, a case in point. In: F.H. van Eemeren, J.A. Blair, C.A. Willard & A.F. Snoek Henkemans (Eds.). *Proceedings of the Fifth Conference of the International Society for the Study of Argumentation* (pp. 289-292). Amsterdam: Sic Sat.
- Ford, S., Schofield, T., & Hope, T. (2002). Barriers to the evidence-based patient choice (EBPC) consultation. *Patient Education and Counselling*, 47, 179-185.
- Forum per la Ricerca Biomedica (2007). *Fiducia, dialogo, scelta. La Comunicazione medico-paziente nella sanità italiana* [Trust, Dialogue, Choice. Doctor-Patient Communication in the Italian Health Care System]. Roma: Censis.
- Godden, D., & Walton, D. (2006). Argument from expert opinion as legal evidence: critical questions and admissibility criteria of expert testimony in the American legal system. *Ratio Juris*, 19(3), 261-286.
- Goodwin, J. (1998). Forms of authority and the real *Ad Verecundiam*. *Argumentation*, 12, 267-280.
- Goodwin, J. (2010). Trust in experts as a principal-agent problem. In: Reed, C. & Tindale, C.W. (Eds.). *Dialectics, Dialogue and Argumentation. An Examination of Douglas Walton's Theories of Reasoning and Argument* (pp. 133-143). London: College Publications.
- Greco, S. (2003). When presupposing becomes dangerous. How the procedure of presuppositional accommodation can be exploited in manipulative discourses. *Studies in Communication Sciences*, 3(2), 217-234.
- Hornberger, J., & Robertus, K. (2005). Comprehensive Evaluations of Health Care Interventions: The Realism-Transparency Tradeoff. *Medical Decision Making*, 25, 490-492.
- Jovičić, T. (2004). Authority-based argumentative strategies: a model for their evaluation. *Argumentation*, 18, 1-24.
- Mead, N., & Bower, P. (2000). Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science and Medicine*, 51, 1087-1110.
- Ong, L.M.L. et al. (1995). Doctor-patient communication: a review of the literature. *Social Science and Medicine*, 40(7), 903-918.
- Pomerantz, A., & Rintel, E.S. (2004). Practices for Reporting and Responding to Test Results during Medical Consultations: Enacting the Roles of Paternalism and Independent Expertise. *Discourse Studies*, 6(1), 9-26.
- Rigotti, E. (2006). Relevance of Context-bound *loci* to Topical Potential in the

Argumentation Stage. *Argumentation*, 20, 519-540.

Rigotti, E., & Greco Morasso, S. (2010). Comparing the Argumentum Model of Topics to other contemporary approaches to argument schemes: the procedural and material components. *Argumentation*, 24(4), 489-512.

Rigotti, E., & Palmieri, R. (2008). Argumentative Interactions in Corporate Deliberation at the General Meeting of Shareholders: The case of Carl Icahn and Motorola. Paper presented at the VIII Amsterdam-Lugano Colloquium on Argumentation Theory. Lugano: USI, 28-29 November 2008.

Rimal, R.N. (2001). Analyzing the Physician-Patient Interaction: An Overview of Six Methods and Future Research Directions. *Health Communication*, 13(1), 89-99.

Roter, D., & Hall, J.A. (2006). *Doctors Talking with Patients/Patients Talking with Doctors*. Westport: Praeger Publishers.

Walton, D. (1997). *Appeal to Expert Opinion*. University Park, PA: The Pennsylvania State University Press.

Walton, D. (2002). *Legal Argumentation and Evidence*. University Park, PA: The Pennsylvania State University Press.

Walton, D. (2006). Examination dialogue: an argumentation framework for critically questioning an expert opinion. *Journal of Pragmatics*, 38, 745-777.

Wasserman, R.C., & Inui, T.S. (1983). Systematic Analysis of Clinician-Patient Interactions: A Critique of Recent Approaches with Suggestions for Future Research. *Medical Care*, 21(3), 279-293.

Wirtz, V., Cribb, A., & Barber, N. (2006). Patient-doctor decision-making about treatment within the consultation - A critical analysis of models. *Social Science and Medicine*, 62, 116-124.